



Whole Person Care Program Referral Form

Phone: (831) 638-3383 Fax: (831) 634-0785 Email: wpcsbcc@cosb.us



Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Referred By

Name: _____ Agency: _____

Phone: _____ Fax: _____ Email: _____

"I, _____ (name), have been told about the Whole Person Care program by _____ (referring person or entity) and would like to be referred and receive more information from the Whole Person Care program."

Client Information

First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Gender (Circle one): M F O

Address Or best location to reach client: _____

Primary Phone: _____ Secondary Phone: _____

E-mail Address: _____ Preferred Language: _____

Please attach copy of Photo ID & Medi-Cal Card (if obtainable)

Eligibility

Following are the criteria on which we will determine the client's eligibility. Check all that apply to this Client:

Person age 18-64

AND

A Medi-Cal beneficiary or Medi-Cal eligible

AND

Homeless or at risk of Homelessness

AND

Meets 1 or more of the characteristics listed below:

Mental Illness

Substance Abuse Disorder

Two (2) or more chronic health diagnoses

Emergency department visits and/or at least one hospitalization in the past 6 months

1 2 3 4 >4

Involved with the criminal justice system

Internal Use Only: WPC# _____ Medi-Cal ID: _____ Date Received: _____

Status: Eligible / NOT Eligible Circle: New /Previous/Existing Client Referral Source Contact Date: _____

Comments: _____